MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

01746

Reg. Dist. No. 1930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Howard

City or town: Poplar Springs
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Poplar Springs
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Irving Amoss

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Cora H.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 11, 1874

8. AGE: Years	Months	Days	If less than one day
72	5	11	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: William H. Amoss
13. Birthplace: Md.

MOTHER
14. Maiden name: Eliza J. Amoss
15. Birthplace: Md.

16. Informant: Mrs. Albert Ridgely

Address: West Friendship, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 26, 1947 (month) (day) (year)

Cemetery or crematory: Mt. View

Location: Howard Co., Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. 2/26/47 (Date rec'd by registrar) E. Earl Mercer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22 1947 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 28 1946 to Feb 22 1947

and that I last saw him alive on Feb. 22 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	2 mo.
Due to:	
Due to:	
Other conditions: Arterio - Sclerosis	? yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or coroner

Address: Mt. Airy - Md Date signed 2/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

01747

Reg. Dist. No. 195

1. PLACE OF DEATH:

County: Harford

City or town: Scaggsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Scaggsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alice Scaggs Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife: Millard F. Brown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 26, 1867

8. AGE: Years	Months	Days	If less than one day
79	4	19	..... hrs. ..... min.

9. Birthplace: Scaggsville, Howard Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Isaac Scaggs
13. Birthplace: Scaggsville, Md.

MOTHER
14. Maiden name: Gelligina Choate
15. Birthplace: Ohio

18. Informant: Ethel M. Mooney

Address: Highland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 16 1947 (month) (day) (year)

Cemetery or crematory: Emmanuel Cemetery

Location: Scaggsville, Maryland

18. Funeral director: Merritt Undertaking Co.

Address: Laurel, Maryland

19. Feb 15 1947 (Date rec'd by registrar) Frank Shipley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14 1947 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to Feb 14 1947

and that I last saw her alive on Feb 14 1947

	DURATION
Immediate cause of death: Apoplexy	1 day
Due to: Hypertension	10 yrs
Due to: Arteriosclerosis	10 yrs
Other conditions: Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. M. Warren M.D.
M. D. or other

Address: Laurel Date signed 2/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

★ 01748

Reg. Dist. No. 1920

1. PLACE OF DEATH:

County Howard

City or town Rural Lyksville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Howard

City or town Rural Lyksville

(If outside city or town limits, write RURAL and give nearest town)

~~Street No.~~ Oakland Farm

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Stevens Crook

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 29, 1871

8. AGE: Years	Months	Days	If less than one day
75	3	16	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Agriculture

FATHER 12. Name James L. Crook

13. Birthplace Md.

MOTHER 14. Maiden name Emily V. Forsythe

15. Birthplace Md.

16. Informant Mrs. Florence Crook Bleisdell

Address Lyksville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 16, 1947 (month) (day) (year)

Cemetery or crematory Mt. View Cemetery

Location Howard Co., Md.

18. Funeral director C. Harry Weer

Address Lyksville, Md.

19. Feb. 15 1947 (Date rec'd by registrar) Alice M. Hebb Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1947, at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 1946, to February 13 1947

and that I last saw him alive on February 13 1947

Immediate cause of death	DURATION
Acute Cardiac Failure	9 days
Due to Myocardial insufficiency	1 year
Due to Coronary arteriosclerosis	5 years
Other conditions Cerebral hemorrhage	5 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles S. Whitaker M.D. M. D. or other

Address Clarksville, Md. Date signed 2-15-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27-a

CERTIFICATE OF DEATH

01749

Reg. Dist. No. 1950

1. PLACE OF DEATH:

County Howard

City or town Near Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Born

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Howard

City or town Savage Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Guilford Rd

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Mary Jane Hall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Nov 2. 1946

8. AGE: Years	Months	Days	If less than one day
—	3	—	... hrs. ... min.

9. Birthplace Warren Hospital Laurel Md

(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name Charles L. Hall

13. Birthplace Md

MOTHER 14. Maiden name Helen Pallman

15. Birthplace Baltimore Md.

16. Informant Charles L. Hall

Address Savage Md.

17. Burial 2/4/47

(Burial, cremation, or removal, which?) Date thereof (month) (day) (year)

Cemetery or crematory St Marys

Location Laurel Md

18. Funeral director W. W. Anderson

Address Laurel. Md.

19. 2/3/47 19... Frank D. Ripley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 1947, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1947, to Jan 2 1947, and that I last saw h.r alive on Jan 2 1947

Immediate cause of death	DURATION
Bacillary dysentery	2 days
Bronchopneumonia	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE J. M. Warren M.D. M. D. or other

Address Laurel Date signed 2/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

01750

Reg. Dist. No. 190

1. PLACE OF DEATH:

County: Howard

City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Lawyers Hill

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Howard

City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lawyers Hill
(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: John Henry Hawkins

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widowed

6.(b) Name of husband or wife: Mary L. Hawkins — 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec 25 1865

8. AGE: Years: 81 | Months: 1 | Days: 25 | If less than one day: ____ hrs. ____ min.

9. Birthplace: St Stephens, Elkridge Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Retired

FATHER — 12. Name: Richard Hawkins

FATHER — 13. Birthplace: Elkridge Md

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: "

16. Informant: Mary Hawkins Wife

Address: Edw St Elkridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 23 1947 (month) (day) (year)

Cemetery or crematory: Daines

Location: Elkridge Md.

18. Funeral director: Mrs. Katie R. Williams

Address: 322 N. Schroeder St.

19. 2/22 1947 (Date rec'd by registrar) O. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19 1947, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 7 1947 to Feb 19 1947 and that I last saw h. alive on Feb 18 1947

	DURATION
Immediate cause of death: Myocardial Insufficiency	1 mo.
Due to: Senile Prostatism	
Due to: Coronal Arteriosclerosis	5 yrs.
Other conditions: Senility	1 Yr.

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op. ____

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Elkridge Md Date signed 2/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01751

Reg. Diat. No. 1936

1. PLACE OF DEATH:
County Howard Co.
City or town Rural. Florence. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 75 Years.
Hospital, Institution, or street address where death occurred:
—
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Rural Florence.
(If outside city or town limits, write RURAL and give nearest town)
Street No. *******
(If rural, give LOCATION) ********
2.(a) If veteran, name war

3.(a) FULL NAME Lucy A. Hilton.

3.(b) Social Security Number *******

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife George F. Hilton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April I7 I87I.

8. AGE: Years	Months	Days	If less than one day
75	9	29	..... hrs. ..... min.

9. Birthplace Howard Co. (Town, county, and state)
10. Usual occupation House Wife.
11. Industry or business

FATHER
12. Name James W, Driver
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden name Mary S. Beall.
15. Birthplace Howard Co. Md.

16. Informant Estella. HIlton
Address Florence Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. I6. 47 (month) (day) (year)
Cemetery or crematory Howard Chapel Md.
Location Howard Co.

18. Funeral director Roy W. Barber
Address Laytonsville Md.

19. 2/16/ 1947 E Raul Spencer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1947, at 4-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 1947, to Feb 13 1947 and that I last saw h.r. alive on Feb 13 1947

Immediate cause of death	DURATION
Cardiac Thrombosis	Short time
Due to Arterio-Sclerosis of Cor	
coronary artery	Unknown
Due to Gradual Arterio Sclerosis	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Vernon H Dyson M D M. D. or other
Address Laytonsville Md Date signed Feb 15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

24 [illegible] N. Charles St., Baltimore

CERTIFICATE OF DEATH

01752 Reg. Dist. No. 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Old Frederick Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Old Frederick Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alice Hunter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Samuel Hunter
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 10, 1879

8. AGE: Years	Months	Days	If less than one day
67	2	25	hrs. min.

8. Birthplace: Carroll Co., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Francis Schick
13. Birthplace: Germany

MOTHER
14. Maiden name: E. June Cook
15. Birthplace: Maryland

16. Informant: Mr. Samuel Hunter
Address: Old Frederick Rd., Ellicott City

17. Entombment (Burial, cremation, or removal. Which?) Date thereof 2/7/47 (month) (day) (year)
Cemetery or crematory: Lorraine Mausoleum
Location: Woodlawn, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 2/6/47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-5 1947 at 9 35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-5 1947 to 2-5 1947 and that I last saw h[illegible] alive on 2-5 1947

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular Disease	1 year
Due to: Acute Pulmonary edema	30 minutes
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George E. Burgtorf M.D.
M. D. or other
Address: Elliott City, Md. Date signed: 2-5-47

Evidence for the change of year of birth is shown on G 108 2/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95a)

CERTIFICATE OF DEATH

01753

Reg. Dist. No. 195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Howard
City or town: Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 82
Hospital, institution, or street address where death occurred: Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Benjamin Franklin Downey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Mary J. Harvey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 27 - 1857 (1857)

8. AGE: Years	Months	Days	If less than one day
89	8	30	hrs. min.

9. Birthplace: Savage Md.
(Town, county, and state)
10. Usual occupation: Farmer - Retired Blacksmith
11. Industry or business

FATHER
12. Name: Richard Downey
13. Birthplace: Prince Geo. Co. Md.

MOTHER
14. Maiden name: Mary Coas
15. Birthplace: Frederick Co. Md.

16. Informant: Mrs. Grace Gleason
Address: 225 Laurel Ave. Laurel Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb-6-1947 (month) (day) (year)
Cemetery or crematory: Savage
Location: Savage Md.
18. Funeral director: The H. C. White Co. Inc.
Address: Laurel, Md.

19. 2/4/47. 19 (Date rec'd by registrar) Frank Shipley, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2nd 1947, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1st 1946 to Feb. 2nd 1947
and that I last saw him alive on Feb. 2nd 1947

Immediate cause of death	DURATION
(a) Stokes-Adams Disease - (Heart Block)	1 wk.
Due to: (b) Arterio-sclerosis	3 yrs.
Due to: (c)	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Shipley, M.D.
Address: Savage, Md. M. D., or other
Date signed: 2/4/47

1 - 25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64-2)

01754

CERTIFICATE OF DEATH

Reg. Dist. No. 1900

1. PLACE OF DEATH:
County: Howard
City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 yrs.
Hospital, Institution, or street address where death occurred: Lawyers Hill Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lawyers Hill Rd
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Cary Gamble Lowndes

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

B.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 24, 1871

8. AGE:

Years	Months	Days	If less than one day
75	11	4	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Retired Banker
11. Industry or business: Banking

FATHER
12. Name: Charles D Lowndes
13. Birthplace: Richmond, Va

MOTHER
14. Maiden name: Nannie Gamble
15. Birthplace: Tallahassee Florida

16. Informant: Pleasonton Conquest
Address: Elkridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 3, 1947 (month) (day) (year)
Cemetery or crematory: Greenmount Cemetery
Location: Baltimore, Md.

18. Funeral director: Henry W. Jenkins + Sons Co.
Address: McCulloh + Orchard Sts.

19. March 1 19 47 (Date rec'd by registrar) (Miss) L. Bird Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28 19 47 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 28 19 47 to Feb 28 19 47 and that I last saw him alive on at no time 19

Immediate cause of death	DURATION
Evisceration of Cranial Contents	1 sec.
Due to: Shotgun wound.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 2-28-47
Where did injury occur? Elkridge (City or town) Howard (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Shotgun wound Injured at work? No

23. SIGNATURE: Alpha M Herbert M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other
Address: Ellicott City, Md. Date signed: 2-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01755

CERTIFICATE OF DEATH

Reg. Diat. No. 194

1. PLACE OF DEATH:
County Howard
City or town West Friendships
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard.
City or town West Friendship
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ivory Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William A Mull

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife Mary E.
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4, 1854

8. AGE:

Years	Months	Days	If less than one day
92	10	29	..... hrs. ..... min.

9. Birthplace Ohio
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name John Mull
13. Birthplace N.J.

MOTHER
14. Maiden name Neoma Botts
15. Birthplace N.J.

16. Informant Mrs. Roland Asbun
Address West Friendships Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-5-47 (month) (day) (year)
Cemetery or crematory Loudon Park.
Location Baltimore Md.

18. Funeral director F.C. Higinbotham
Address Ellicott City Md

19. Feb 4 1947 (Date rec'd by registrar) Marie A. Whitaker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1947, at 80 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11 1947 to January 21 1947 and that I last saw h. l.m. alive on January 21 1947

Immediate cause of death	DURATION
Acute cardiac failure	12 hrs
Due to Hypertensive heart disease	20 yrs
Due to Arteriosclerosis	30 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles S. Whitaker, M.D.
M. D. or other
Address Clarksville, Md. Date signed 2-4-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126-a)

CERTIFICATE OF DEATH

★ 01756

Reg. Dist. No. 191

1. PLACE OF DEATH:
County HOWARD
City or town RURAL - ELLICOTT CITY MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? NINE DAYS
Hospital, institution, or street address where death occurred:
PINEL CLINIC - ELLICOTT CITY
How long in hospital or institution? NINE DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County Dorch.
City or town CAMBRIDGE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ANNA PRESSNER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DAY + MONTH UNKNOWN 1867

8. AGE: Years	Months	Days	If less than one day
80	2	2	hrs. min.

9. Birthplace AUSTRIA (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business
12. FATHER Name MAX STERNBERG
13. FATHER Birthplace AUSTRIA
14. MOTHER Maiden name LEAL
15. MOTHER Birthplace AUSTRIA
16. Informant MRS. PHILLIP FRANKEL
Address CAMBRIDGE - MD.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof FEB. (month) (day) (year)
Cemetery or crematory MT. ZION
Location MASPITH LONG ISLAND NY.
18. Funeral director Easton Sons
Address Ellicott City, Md.
19. Feb. 25, 1947 (Date rec'd by registrar) John B. Lyng Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 25th 1947 at 7 30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEBRUARY 17th 1947 to FEBRUARY 25th 1947 and that I last saw h.e.r. alive on FEBRUARY 25th 1947

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	5 HOURS
Due to GENERALIZED ARTERIOSCLEROSIS	2 YEARS
Due to Accidental Fall. Cut L.B.	
Other conditions FRACTURE OF NECK OF LEFT FEMUR	11 DAYS ?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Feburary 10. 1947
Where did injury occur? Cambridge (City or town) Dorchester (County) Maryland (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury Fall. Injured at work?

23. SIGNATURE Helmut Prager M.D
M. D. or other
Address Ellicott City Md Date signed 2/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 22a

01757

CERTIFICATE OF DEATH

Reg. Diat. No. 1920

1. PLACE OF DEATH:
County: Howard
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: LEVI E. THOMAS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 1, 1904

8. AGE:

Years	Months	Days	If less than one day
42	5	11	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business

FATHER
12. Name: Alpheus Thomas
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bessie Dorsey
15. Birthplace: Maryland

18. Informant: Alpheus Thomas
Address: Sykesville, Md.

17. (Burial, ~~cremation, or removal. Which?~~) Burial
Date thereof 2- 15-47 (month) (day) (year)
Cemetery ~~or crematory~~: White Rock
Location: Berrett, Carroll Co. Md.

18. Funeral director: C. M. Waltz
Address: Winfield, Md.

19. (Date rec'd by registrar) Feb 17 1947 Alice M. Hilt, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12, 1947, at 12:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1947, to Feb 12 1947
and that I last saw him alive on Feb 12 1947

Immediate cause of death	DURATION
a acute miliary tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. H. Lawrence, M.D.
M. D. or other
Address: Sykesville, Md. Date signed 2/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35